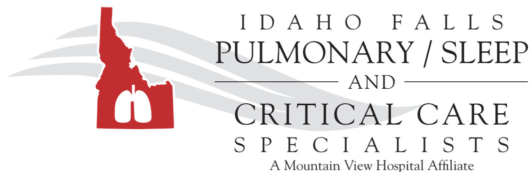


PULMONARY SLEEP MEDICINE INITIAL EVALUATION

ALLEN J. SALEM M.D., F.C.C.P.
JOSHUA KILLPACK P.A.-C.

Date:____________________________

Name:____

Referring Physician:________________________________ **Family Physician:**__________________________

Other Physician:____________________________

HISTORY OF PRESENT ILLNESS

Check the box for all those that apply.

❒ **Unable to catch your breath**

❒ with exercise ❒ at rest ❒ wakes you from sleep

How long have you had shortness of breath?______________________________

❒ **Wheezing**

❒ as a child ❒ daily ❒ at night ❒ with exercise

❒ **Difficulty laying flat or with one pillow**

❒ **Night sweats**

❒ **Cough**

How long have you experienced the cough?____________________________

❒ **Producing sputum** ❒ no or minimal sputum

If yes describe: ____

❒ **Fevers / Night Sweats**

If yes explain:____

❒ **Wt. loss**

If yes explain:____

❒ **Leg swelling**

For how long?____

❒ **Nasal drainage**

❒ clear ❒ colored ❒ daytime ❒ at night

❒ **Acid indigestion / Heart Burn**

❒ daily ❒ weekly ❒ If yes for how long?

❒ **Seasonal Allergies:** ❒ winter ❒ spring ❒ summer ❒ fall

To what? (if known):____

❒ **Loss of appetite**

❒ **Chest pain** If yes describe:

❒ **Snoring**

❒ **Non-refreshing sleep**

Have you ever used diet pills of any kind including Metabolife or any other ephedra containing products? ❒ yes ❒ no

If yes, what, and for how long?______________________________________

CLINICIAN COMMENTS

HPI:

SLEEP HISTORY

Past sleep evaluation and treatment

❒ I have had a previous sleep disorder evaluation

When ______________________ Where ______________________

❒ I have had previous overnight sleep studies

When ______________________ Where ______________________

❒ I have had daytime nap studies

When ______________________ Where ______________________

❒ I have been prescribed a CPAP or bi-level machine for home use.

When ____________ DME ______________________________

❒ I have had surgical treatment for a sleep disorder

When ____

❒ I have previously been prescribed medication fro a sleep disorder

Name of Medication: ______________________________________

Sleep Patterns	Work Days	Off Days
Typical Bedtime	______________	______________
Typical Wake Time	______________	______________
Typical amount of time it takes to fall asleep	______________	______________
Do you nap	❒ Yes ❒ No	❒ Yes ❒ No
If yes, are naps refreshing	❒ Yes ❒ No	❒ Yes ❒ No

For how long ❒ <30 min ❒ 30 min - 1 hr ❒ >1 hr

❒ I work rotating shifts. Describe:______________________________________

❒ I am a permanent or long term third shift worker.

❒ I share the bedroom and bed with someone.

- ❒ My child sleeps in my bed.

❒ I share a bedroom with someone, but have separate beds.

- ❒ My pets sleep in my bed.

❒ I share a dwelling with someone but have separate bedrooms.

❒ I live alone.

Sleep Problems / Observations

❒ I have difficulty concentrating.

❒ I have a tendency to be drowsy during the day.

❒ I have had or nearly had auto accidents as a result of falling asleep or nodding off while driving.

❒ I have had injuries as the result of sleepiness during work.

❒ I regularly experience an overwhelming urge to sleep.

❒ I have experienced an inability to move while falling asleep or when waking up.

❒ I experience sudden muscular weakness (or even brief periods of paralysis, being unable to move) when laughing, angry, or in situations of strong emotion.

❒ I have experienced hallucinations or dreamlike images or sounds when falling asleep or waking.

❒ I experience a creepy-crawling or tingling sensation in my legs when I try to fall asleep.

CLINICIAN COMMENTS

- ❒ I experience an inability to keep my legs still prior to falling asleep. Movement improves this.
- ❒ I work rotating shifts.
- ❒ I usually watch TV or read in bed prior to sleep.
- ❒ I frequently travel across 2 or more time zones.
- ❒ I drink alcohol within 1 hour of bedtime.
- ❒ I smoke cigarettes within 1 hour of bedtime.
- ❒ I am told I grind my teeth in my sleep.
- ❒ I typically awaken to urinate more than once at night.
- ❒ I have trouble falling asleep ❒ every night ❒ more than twice a week
- ❒ I awaken frequently during the night ❒ every night ❒ more than twice a week.
- ❒ I am unable to return to sleep easily if I awaken during the night.
- ❒ I awaken early in the morning, still tired but unable to return to sleep.
- ❒ I have recently experienced sleep walking/talking or acting out of dreams.
- ❒ I have sleep walked as an adult.
- ❒ I have been told that I stop breathing while asleep.
- ❒ I awaken at night choking, smothering or gasping for air.
- ❒ I have been told that I snore.
- ❒ I have been told that I snore only when sleeping on my back.
- ❒ I have been awakened by my own snoring.
- ❒ I kick or jerk my legs and/or arms during sleep.
- ❒ I sweat a great deal during sleep.
- ❒ I cannot sleep on my back.
- ❒ I experience morning headaches.
- ❒ I awaken with nasal stuffiness that was not present when I fell asleep.
- ❒ I feel I am anxious.
- ❒ I have racing thoughts at sleep time.
- ❒ It is difficult to turn my mind off at night.
- ❒ There have been recent significant changes in my life/career.

PAST MEDICAL HISTORY

- ❒ Hypertension
- ❒ Congestive Heart Failure
- ❒ Alcohol Addiction
- ❒ Drug Abuse
- ❒ Chronic Pain
- ❒ Head Injury / Trauma
- ❒ Anxiety
- ❒ Seizures/History of Seizures
- ❒ Cancer
- ❒ Thyroid Problems
- ❒ Hepatitis/Jaundice
- ❒ Diabetes
- ❒ Asthma
- ❒ Arthritis
- ❒ Blood Clots
- ❒ Depression/Severe Anxiety
- ❒ Acid Indigestion/Heart Burn
- ❒ Stomach or Colon Problems
- ❒ Fibromyalgia
- ❒ Stroke
- ❒ COPD
- ❒ Myocardial Infartction (Heart Attack)
- ❒ Arrhythmia (Atrial Fibrillation)

Female

- ❒ Menopausal

Male

- ❒ Prostate Problems
- ❒ Erectile Dysfunction
- ❒ Bleeding Problem

CLINICIAN COMMENTS

Past Medical Hx

Past Surgical History (Include the approximate date of surgery)

List all surgeries in the past 5 years

	Date		Date
❒ Tonsillectomy	___________	❒ Bariatric Surgery	___________
❒ Nasal Surgery	___________	❒ Prostate Surgery	___________
❒ Throat Surgery	___________	❒ Hysterectomy	___________
❒ Thyroid Surgery	___________	❒ Back Surgery	___________
❒ Heart Surgery	___________	❒ Neck Surgery	___________
❒ Upper Endoscopy	___________	❒ Breast Removal (Lumpectomy)	___________
❒ Lung Biopsy	___________		
❒ Coronary Stents	___________	❒ Cardiac Bypass	___________
❒ Cholecystectomy	___________	❒ Gastric Bypass	___________
❒ Colonscopy	___________	❒ Pacemaker	___________
❒ Bronchscopy	___________	❒ Removal of Spleen	___________
❒ Other	___________	❒ Breast or lump removal	___________

Occupational Lung History

Check any that you have been exposed to work or as a hobby.

❒ asbestos ❒ silica ❒ ceramic dust ❒ grain dust

❒ chemicals ❒ worked in barn ❒ raised birds ❒ silo work

Current Occupation: ____

Social History

Marital status:

❒ single ❒ married ❒ widowed ❒ divorced

Did you ever smoke: ❒ yes ❒ no ❒ Quit / when ________________

If yes, how long?_____ years _____ packs per ❒ day ❒ week

Do you smoke currently? ❒ yes ❒ no

If yes, how often?_____ packs per ❒ day ❒ week

Do you want to quit? ❒ yes ❒ no

Have you ever quit? ❒ yes ❒ no

Alcohol use: ❒ daily ❒ rarely ❒ social ❒ never

Oxygen use? ❒ yes ❒ no

If yes, how many liters?_____ liters DME _________________________

FAMILY HISTORY

Has any immediate blood relatives had any of the following?

Yes	No		Relation	Yes	No		Relation
❒	❒	Cancer	__________	❒	❒	Stroke	__________
❒	❒	Diabetes	__________	❒	❒	Anxiety/Depression	__________
❒	❒	Hypertension	__________	❒	❒	Sleep Apnea	__________
❒	❒	Heart Disease	__________	❒	❒	Narcolepsy	__________
❒	❒	Thyroid Disease	__________	❒	❒	COPD	__________
❒	❒	Emphysema	__________	❒	❒	Other	__________
❒	❒	Pulmonary embolism					

CLINICIAN COMMENTS

Past Surgical Hx

Occupational Hx

Social Hx

Family Hx

REVIEW OF SYSTEMS

Circle all that apply and explain

- ❒ Shortness of breath or wheezing; chest pain or pressure or heaviness; irregular heartbeat
- ❒ Lack of energy; trouble sleeping; loss of appetite; weight changes; fevers, unintentional weight loss
- ❒ Eye problems, such as double or blurred vision
- ❒ Hearing problems, such as buzzing or ringing in ears; difficulty swallowing or food sticking; hoarsness for four weeks
- ❒ Allergies; hayfever; nasal stuffiness; nasal drainage; nosebleeds
- ❒ Cough for four weeks; cough up blood
- ❒ Stomach problems; indigestion; frequent heart burn; change in bowel habits; abdominal pain
- ❒ Bloddy stools; frequent diarrhea, frequent constipation; rectal bleeding; black stools
- ❒ Urinary problems; frequency; infections; stones; blood in urine; In men any prostate problmes; urination more than once at night
- ❒ Back or joint pains; swelling or redness; arthritis; back pain
- ❒ Chronic joint pain
- ❒ Rash, itching or other skin problems
- ❒ Seziures; loss of memory, headaches
- ❒ Unusual thoughts; nervousness; crying or sadness; depression
- ❒ Thyroid disorders; diabetes; excess thirst; hunger or urination; swelling in feet or ankles
- ❒ Problems with sleep;
- ❒ Frequent headaches; fainting or passing out
- ❒ Visual Impairment
- ❒ Hearing Impairment

CLINICIAN COMMENTS ROS

BECK INVENTORY

A. 0. I do not feel sad
1. I feel sad at times.
2. I am sad all the time and I can't snap out of it.
3. I am so sad or unhappy that I can't stand it.

B. 0. I am not particularly guilty
1. I feel discouraged about the future.
2. I feel I have nothing to look forward to.
3. I feel that the future is hopeless and that things can not improve

C. 0. I am not a failure
1. I feel I have failed more than the average person
2. As I look back on my life, all I can see is a lot of failure
3. I feel I am dissatisfied or bored with everything

D. 0. I get as much satisfaction out of things as I used to
1. I do not enjoy things the way I used to
2. I do not get real satisfaction out of anything anymore
3. I am dissatisfied or bored with everything

E. 0. I do not feel particularly guilty
1. I feel guilty a good part of the time
2. Ifeel quite guilty most of the time
3. I feel guilty all the time

F. 0. I do not feel I am being punished
1. I feel I am being punished unnecessarily
2. I expect to be punished
3. I feel I am being punished all the time.

G. 0. I do not feel disappointed in myself
1. I am disappointed in myself at times
2. I am disgusted with myself
3. I hate myself

H. 0. I do not feel I am any worse than anybody else
1. I am critical of myself for my weakness or mistakes
2. I blame myself all the time for my faults
3. I blame myself for everything bad that happens

I. 0. I do not have any thoughts of killing myself
1. I have thought of killing myself, but I would not carry them out
2. I would be better off dead
3. I would kill myself if I had the chance

CLINICIAN COMMENTS

J. 0. I do not cry anymore than usual
1. I cry more now than I used to
2. I cry all the time now
3. I would kill myself if I had the chance

K. 0. I don't get irritated often
1. I get annoyed or irritated more easily than I used to
2. I feel irritated all the time

L. 0. I make decisions as best as I have ever been able to
1. I put off making decisions more than I used to
2. I have a greater difficulty in making decisions than before
3. I can not make decisions at all anymore

M. 0. I do not feel I look any worse than I used to
1. I am worried that I am looking old or unattractive
2. I look ugly

N. 0. I can work about as well as before
1. It takesan extra effort to get started at doing something
2. I have to push myself very hard to do anything
3. I can not do any work at all

O. 0. I can sleep as well as usual
1. I have great difficulty falling asleep
2. I wake up 2-3 hours earlier than usual and find it hard to get back to sleep

P. 0. My energy level is good
1. My energy level is less than usual
2. My energy level has greatly decreased
3. I am too tired to do anything

Q. 0. My appetite is no worse than usual
1. My appetite is not as good as it used to be
2. My appetite is much worse now
3. I have no appetite

R. 0. I am not more worried about my health than usual
1. I am worried about my physical problems such as aches and pains, or upset stomach or constipation
2. I am very worried about my physical problems and it is hard to think of much else
3. I am so worried about my physical problems that I can't do much else

S. 0. I have not noticed any recent change in my interest in sex
1. I am less interested in sex than I used to be
2. I am much less interested in sex now
3. I have lost interest in sex completely

CLINICIAN COMMENTS

PHYSICAL EXAM

(TO BE COMPLETED BY STAFF ONLY)

Name: ____________________

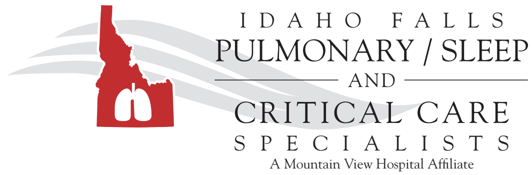
Date: ____________________

BP________ **P**_________ **SAO2**___________ **HT**______________ **WT**______________ **BMI**_______

General Appearance:	❒ WNL	❒ Obese	❒ Cacethic		
Head:	❒ AT/NC	❒	❒ Retrognathia		
Eyes:	❒ PERRLA		**Ears:** ❒ Normal		
Nose:	❒ Normal	❒ Deviated Septum			
Terbinates:	❒ Normal	❒ Edema	❒ Pale	❒ Bleeding	
Soft Palate	❒ Normal	❒ Elongated	**Uvula** ❒ Normal	❒ Enlarged	❒ Absent
Tonsils	❒ Normal	❒ Enlarged	❒ Absent	❒ Not visualized	
Tounge	❒ Normal	❒ Lingular Enlargement		❒ Low in Mandible	
Mallapatti:	❒ I	❒ II	❒ III	❒ IV	
Neck:	❒ Normal	❒ >17”			
Respiratory:	❒ Normal	❒ Wheezes	❒ Rales	❒ Rhonci	❒ Diminished Breath Sounds
❒ L ❒ R	❒ Bilateral				
Cardiac:	❒ Normal	❒ RRR	❒ Irregular	❒ Murmur	
Abdominal:	❒ Normal	❒ Obese			
Skin:	❒ Normal	❒ Rash	❒ Bruising		
Extremities:	❒ Normal	❒ Edema	❒ L ❒ R	❒ Clubbing	
Pulses:	❒ Normal	❒ Decreased	❒ L ❒ R		
Neuro:	❒ Grossly Normal	❒ Abnormal			

ASSESSMENT PLAN

This entire document has been personally reviewed by provider ____________________ **RV** __________



CURRENT MEDICATIONS

ALLEN J. SALEM M.D., F.C.C.P.
JOSHUA KILLPACK P.A.-C.

	Medication	Dose (mg)	# Times per Day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

	Drug Allergies	Reaction
1.		
2.		
3.		
4.		